		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Road (Number) Glen Carbon (City) 62034 (Zip Code)

County: Madison

Telephone Number: (618) 288-5014 **Fax #** (618) 288-0206

IDPA ID Number: 37-10332262001

Date of Initial License for Current Owners: 5/14/1979

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Allan B. Larson, CPA **Telephone Number:** (314) 336-3679

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Jane Rubin
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) Larson, Allen, Weishair & Co., LLP, 12801 Flushing Meadows Drive, Suite 100
(Telephone) (314) 336-3600 Fax # 314-336-3650

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	138	Skilled (SNF)	138	50,508	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,508	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,851	24,109	2,963	45,923	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,851	24,109	2,963	45,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.92%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 05/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 05/14/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 138 and days of care provided 2,963

Medicare Intermediary Mutual of Omaha, P.O. Box 1602, Omaha, NE 68101

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	292,555	29,903	8,200	330,658	(5,230)	325,428	(35,222)	290,206			1
2	Food Purchase		317,162		317,162		317,162	(33,785)	283,377			2
3	Housekeeping	188,087	21,269	8,042	217,398		217,398	(108,435)	108,963			3
4	Laundry	84,502	21,269		105,771		105,771	(39,516)	66,255			4
5	Heat and Other Utilities			221,369	221,369		221,369	(110,415)	110,954			5
6	Maintenance	173,776	16,731	190,360	380,867		380,867	(189,970)	190,897			6
7	Other (specify):*											7
8	**TOTAL General Services**	738,920	406,334	427,971	1,573,225	(5,230)	1,567,995	(517,343)	1,050,652			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	2,094,980	209,324	75,384	2,379,688	(90,583)	2,289,105		2,289,105			10
10a	Therapy		2,376	267,039	269,415		269,415		269,415			10a
11	Activities	122,767	4,055	2,859	129,681		129,681		129,681			11
12	Social Services	53,230	629	404	54,263		54,263		54,263			12
13	Nurse Aide Training			12,367	12,367		12,367		12,367			13
14	Program Transportation	32,776	2,983	10,811	46,570		46,570	(17,399)	29,171			14
15	Other (specify):* Senior Fit	45,460	725	22,518	68,703		68,703	(68,703)				15
16	**TOTAL Health Care and Programs**	2,349,213	220,092	408,182	2,977,487	(90,583)	2,886,904	(86,102)	2,800,802			16
	C. General Administration											
17	Administrative	113,892	584	47,653	162,129		162,129	(92,706)	69,423			17
18	Directors Fees											18
19	Professional Services			70,159	70,159		70,159	(14,184)	55,975			19
20	Dues, Fees, Subscriptions & Promotions			31,412	31,412		31,412	(22,443)	8,969			20
21	Clerical & General Office Expenses	199,057	12,467	98,265	309,789		309,789	(115,738)	194,051			21
22	Employee Benefits & Payroll Taxes			786,986	786,986	5,230	792,216	(30,799)	761,417			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,523	8,523		8,523	(4,583)	3,940			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			165,687	165,687		165,687	(18,086)	147,601			26
27	Other (specify):* Marketing	7,615	1,327	15,796	24,738		24,738	(24,738)				27
28	**TOTAL General Administration**	320,564	14,378	1,224,481	1,559,423	5,230	1,564,653	(323,277)	1,241,376			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,408,697	640,804	2,060,634	6,110,135	(90,583)	6,019,552	(926,722)	5,092,830			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eden Village Care Center #0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			545,861	545,861		545,861	(259,729)	286,132			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			114,295	114,295		114,295	(3,600)	110,695			32
33	Real Estate Taxes			45,000	45,000		45,000	(45,000)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			705,156	705,156		705,156	(308,329)	396,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					90,583	90,583		90,583			39
40	Barber and Beauty Shops		3,304	24,559	27,863		27,863		27,863			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,716	75,716		75,716		75,716			42
43	Other (specify):*	138,835		123,188	262,023		262,023	(262,023)				43
44	**TOTAL Special Cost Centers**	138,835	3,304	223,463	365,602	90,583	456,185	(262,023)	194,162			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,547,532	644,108	2,989,253	7,180,893		7,180,893	(1,497,074)	5,683,819			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(68,703)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,134)	17		24
25	Fund Raising, Advertising and Promotional	(22,443)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,373,794)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,497,074)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,497,074)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		90,583	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 90,583		47

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation - Non-Care Assets (RC & Autos)	$ (259,729)	30	1
2	Non-Allowable Travel/Seminars	(4,583)	24	2
3	Marketing	(24,738)	27	3
4	Real Estate Taxes	(45,000)	33	4
5	Interest Expense - RC	(3,600)	32	5
6	Legal Fees - RE Exception (RC)	(14,184)	19	6
7	RC (Retirement Center) - Dietary	(35,222)	1	7
8	RC - Food	(33,785)	2	8
9	RC - Housekeeping	(108,435)	3	9
10	RC - Laundry	(39,516)	4	10
11	RC - Heat & Utilities	(110,415)	5	11
12	RC - Maintenance	(189,970)	6	12
13	RC - Program Transportation	(17,399)	14	13
14	RC - Administrative	(60,572)	17	14
15	RC - Clerical & Office	(115,738)	21	15
16	RC - Employee Benefits/PR Taxes	(30,799)	22	16
17	RC - Insurance	(18,086)	26	17
18	RC - Direct Expenses	(262,023)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,373,794)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(35,222)	0	0	0	0	0	0	0	0	0	0	(35,222)	1
2	Food Purchase	(33,785)	0	0	0	0	0	0	0	0	0	0	(33,785)	2
3	Housekeeping	(108,435)	0	0	0	0	0	0	0	0	0	0	(108,435)	3
4	Laundry	(39,516)	0	0	0	0	0	0	0	0	0	0	(39,516)	4
5	Heat and Other Utilities	(110,415)	0	0	0	0	0	0	0	0	0	0	(110,415)	5
6	Maintenance	(189,970)	0	0	0	0	0	0	0	0	0	0	(189,970)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(517,343)	0	0	0	0	0	0	0	0	0	0	(517,343)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(17,399)	0	0	0	0	0	0	0	0	0	0	(17,399)	14
15	Other (specify):*	(68,703)	0	0	0	0	0	0	0	0	0	0	(68,703)	15
16	**TOTAL Health Care and Programs**	(86,102)	0	0	0	0	0	0	0	0	0	0	(86,102)	16
	C. General Administration													
17	Administrative	(92,706)	0	0	0	0	0	0	0	0	0	0	(92,706)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,184)	0	0	0	0	0	0	0	0	0	0	(14,184)	19
20	Fees, Subscriptions & Promotions	(22,443)	0	0	0	0	0	0	0	0	0	0	(22,443)	20
21	Clerical & General Office Expenses	(115,738)	0	0	0	0	0	0	0	0	0	0	(115,738)	21
22	Employee Benefits & Payroll Taxes	(30,799)	0	0	0	0	0	0	0	0	0	0	(30,799)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,583)	0	0	0	0	0	0	0	0	0	0	(4,583)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(18,086)	0	0	0	0	0	0	0	0	0	0	(18,086)	26
27	Other (specify):*	(24,738)	0	0	0	0	0	0	0	0	0	0	(24,738)	27
28	**TOTAL General Administration**	(323,277)	0	0	0	0	0	0	0	0	0	0	(323,277)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(926,722)	0	0	0	0	0	0	0	0	0	0	(926,722)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(259,729)	0	0	0	0	0	0	0	0	0	0	(259,729)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,600)	0	0	0	0	0	0	0	0	0	0	(3,600)	32
33	Real Estate Taxes	(45,000)	0	0	0	0	0	0	0	0	0	0	(45,000)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(308,329)	0	0	0	0	0	0	0	0	0	0	(308,329)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(262,023)	0	0	0	0	0	0	0	0	0	0	(262,023)	43
44	**TOTAL Special Cost Centers**	(262,023)	0	0	0	0	0	0	0	0	0	0	(262,023)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,497,074)	0	0	0	0	0	0	0	0	0	0	(1,497,074)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Village of Glen Carbon		x	Construction & Equipment		12/31/96	$ 2,300,000	$ 1,295,000	10/01/2011	5.1-5.8%	$ 78,463	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,300,000	$ 1,295,000			$ 78,463	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,300,000	$ 1,295,000			$ 78,463	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 45,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 45,000	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 45,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 45,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	26,526	8
	2000	38,828	9
	2001	41,968	10
	2002	43,587	11
	2003	44,228	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (618) 288-5014 FAX #: (618) 288-0206

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-2-15-26-02-202-165	Eden Village Subd 1st Addn Lot 1	$ 35,057.27	$
2.	14-2-12-26-02-202-096	Cottonwood Trace PT Lot 3	$ 75.76	$
3.	14-2-15-26-02-202-097	Cottonwood Trace PT Lot 2	$ 8,122.29	$
4.	14-2-15-26-02-202-101	Cottonwood Trace - First Addn LT PT	$ 946.21	$
5.	14-1-15-26-02-202-098.001	NE/C NE	$ 26.38	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,227.91	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,240 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eden Retirement Center, Independent Living Facility (80 apartments; 36 duplex units)
Eden Childcare Center, Child Daycare Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LAND - SNF		1979	$ 166,295	1
2					2
3	TOTALS			$ 166,295	3

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1979	1979	$ 2,008,520	$ 66,950	30	$ 66,950	$	$ 1,718,304	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Landscaping-398			1993	809		10			809	10
11	Flower bed irrigation system-786			1997	2,450	163	15	163		1,170	11
12	Parking lot-13			1979	62,453		10			62,453	12
13	Alarm system-29			1979	1,193		10			1,193	13
14	Additions-106			1985	28,766	959	30	959		18,459	14
15	Roof-239			1989	21,453	1,073	20	1,073		16,627	15
16	Office addition-269			1990	34,575	1,152	30	1,152		16,518	16
17	Interior office walls-280			1991	3,102	124	25	124		1,737	17
18	Gas pipe-283			1991	5,850	234	25	234		3,257	18
19	Parking lot-311			1991	8,447	563	15	563		7,415	19
20	Floor-kitchen-308			1991	3,046	152	20	152		2,017	20
21	Blocks-parking lot-279			1991	391	26	15	26		364	21
22	Building remodeling-348			1991	104,840	4,194	25	4,194		51,023	22
23	Paved entrance drive-330			1992	1,890	126	15	126		1,596	23
24	Gutters-399			1993	293	15	20	15		169	24
25	Fence-400			1993	700	47	15	47		537	25
26	Patio roof-401			1993	3,285	164	20	164		1,889	26
27	Roof-424			1993	10,956	548	20	548		6,163	27
28	Signs-441			1993	6,956	580	12	580		6,426	28
29	Remodel hall I-425			1993	23,174	927	25	927		10,429	29
30	Remodel hall III-442			1993	20,060	802	25	802		8,893	30
31	Walkpads-365			1993	1,085	54	20	54		650	31
32	Driveway seal-433			1993	950	48	20	48		532	32
33	Parking lot-482			1994	3,188	159	20	159		1,674	33
34	Remodel hall III-454			1994	10,620	425	25	425		4,602	34
35	Improvements-462			1994	2,896	193	15	193		2,075	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remodel hall V-455	1994	$ 8,141	$ 325	25	$ 325	$	$ 3,527	37
38	Improvements-506	1994	650	43	15	43		443	38
39	Improvements-519	1994	138	9	15	9		92	39
40	Crash Rails-525	1994	3,070	205	15	205		2,064	40
41	Improvements-608	1995	2,841	142	20	142		1,302	41
42	Rubber roof installation-583	1995	23,522	1,176	20	1,176		11,075	42
43	Rubber roof installation-609	1995	23,522	1,176	20	1,176		10,781	43
44	Shower room improvements-619	1995	6,285	314	20	314		2,854	44
45	Improvements-541	1995	2,360	118	20	118		1,160	45
46	Improvements room 501-554	1995	1,800	90	20	90		878	46
47	Improvements room 403 405 407-555	1995	5,400	270	20	270		2,633	47
48	Improvements room 400 401-556	1995	4,035	202	20	202		1,967	48
49	Improvements room 409 411 413-567	1995	5,400	270	20	270		2,587	49
50	Improvements room 408 410 412-572	1995	5,754	288	20	288		2,734	50
51	Improvements room 402 404 406-584	1995	5,594	280	20	280		2,635	51
52	Design & engineering cost-546	1995	4,410	221	20	221		2,151	52
53	Improvements-622	1996	1,867	93	20	93		840	53
54	Crash rails-627	1996	2,829	189	15	189		1,683	54
55	Remodel rooms 509 511 513-635	1996	7,080	354	20	354		3,098	55
56	Remodel rooms 503 505 507-641	1996	7,080	354	20	354		3,098	56
57	Install phone jacks-645	1996	210	21	10	21		182	57
58	Remodel rooms 502 504 506-650	1996	7,080	354	20	354		3,068	58
59	Install phone jacks-656	1996	210	21	10	21		180	59
60	Remodel rooms 508 510 512-668	1996	7,080	354	20	354		3,009	60
61	Remodel rooms 209 211 213-684	1996	7,080	354	20	354		2,950	61
62	Remodel rooms 203 205 207-699	1996	7,080	354	20	354		2,921	62
63	Remodel rooms 200 202 204-708	1996	7,080	354	20	354		2,891	63
64	Remodel rooms 206 208 210-715	1996	7,080	354	20	354		2,862	64
65	Remodel room 212-719	1996	2,360	118	20	118		954	65
66	Roof repair-769	1997	3,550	177	20	177		1,301	66
67	Prep and paint walls-1/2 -500	1994	13,333	1,333	10	1,333		13,333	67
68	Vinyl fence-852	1998	3,731	249	15	249		1,721	68
69	Parking lot asphalt-922	1998	18,949	1,895	10	1,895		12,001	69
70	TOTAL (lines 4 thru 69)		$ 2,578,549	$ 91,735		$ 91,735	$	$ 2,051,956	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,578,549	$ 91,735		$ 91,735	$	$ 2,051,956	1
2	Expansion carpet & wallcovering-806	1998	14,587	0	5	0		14,587	2
3	Carpet-admin & chapel-853	1998	19,121	319	5	319		19,121	3
4	Wall covering-lobby-877	1998	876	88	10	88		607	4
5	Walk off pad-873	1998	1,514	101	15	101		698	5
6	Wall covering-therapy-881	1998	1,603	160	10	160		1,095	6
7	Wall coverings-7 rooms-898	1998	17,500	1,750	10	1,750		11,375	7
8	Expansion construction-admin & patient rooms-807	1998	895,205	22,380	40	22,380		156,661	8
9	Expansion construction-therapy center-850	1998	522,203	13,055	40	13,055		90,297	9
10	Construction-eng & archit fees-851	1998	126,455	4,215	30	4,215		29,154	10
11	Roof repair-886	1998	7,452	745	10	745		5,030	11
12	Design cost-993	1999	734	24	30	24		144	12
13	Corner protectors-1018	1999	1,701	113	15	113		642	13
14	17 fire/smoke dampers-985	1999	22,104	1,474	15	1,474		8,842	14
15	Electrical circuit installations-1037	1999	447	29	15	29		163	15
16	Wall coverings: halls 1 & 2, nurses station-997,1004,1008,1024,106	1999	4,412	441	10	441		2,501	16
17	Alarm system repair-1025	1999	1,840	123	15	123		685	17
18	Sprinkler system improv.-1021	1999	3,135	209	15	209		1,167	18
19	Engineering consulting-1057	1999	899	60	15	60		315	19
20	Wallcoverings: halls 3 & 4, main hall-971 & 972	1999	10,329	1,033	10	1,033		6,198	20
21	Crash rail-973	1999	25,475	1,698	15	1,698		10,189	21
22	Wallcoverings: dining room, alzh dining area-1009 & 1019	1999	9,925	992	10	992		5,669	22
23	Alzheimers construction-1026	1999	504,922	12,623	40	12,623		70,479	23
24	100' vinyl fence-1069	1999	1,383	92	15	92		476	24
25	Signage program-1000	1999	20,523	1,368	15	1,368		7,981	25
26	Courtyard landscaping-1044	1999	8,900	890	10	890		4,821	26
27	Pond sidewalk-1046	1999	3,485	232	15	232		1,258	27
28	Monumental plaque-987	1999	148	15	10	15		89	28
29	Custom door, frame, hinges-1103	2000	555	56	10	56		274	29
30	Final CC renovation payment-1113	2000	11,000	275	40	275		1,306	30
31	Carpet-service hall-1165	2000	2,444	489	5	489		1,997	31
32	Chair rails-1167	2000	5,843	584	10	584		2,385	32
33	Wallpaper & flooring, activity room-1150	2000	1,537	307	30	307		1,306	33
34	TOTAL (lines 4 thru 69)		$ 4,826,806	$ 157,675		$ 157,675	$ 0	$ 2,509,468	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,826,806	$ 157,675		$ 157,675	$	$ 2,509,468	1
2	Linoleum, activity room-1161	2000	5,523	1,104	5	1,104		4,601	2
3	Sidewalk-1162	2000	4,235	212	20	212		883	3
4	Alzheimers construction-final	2001	31,865	2,124	15	2,124		8,143	4
5	Landscaping-CC/Therapy	2001	4,865	486	10	486		1,742	5
6	Painting-main hall & lobby bathrooms	2001	1,774	177	10	177		635	6
7	RipRap (rock)-lake	2001	1,109	111	10	111		388	7
8	Parking lot sealing/striping-CC/Therapy	2001	7,183	718	10	718		2,334	8
9	Install delayed egress on doors	2001	3,400	340	10	340		1,048	9
10	Trees-removal	2001	585	59	10	59		196	10
11	Roof repairs	2001	3,148	315	10	315		1,128	11
12	Heat tape in down spouts	2001	4,905	491	10	491		1,759	12
13	Upgrade parking lighting-0955	1998	3,750	250	15	250		1,521	13
14	Nurse stn A/C unit	2001	916	92	10	92		329	14
15	Employee lounge-2081	2002	3,150	126	25	126		273	15
16	Front receptionist desk-2084	2002	2,400	96	25	96		200	16
17	Nurses station hall 6-2085	2002	800	32	25	32		67	17
18	Nurses station hall 6-2086	2002	2,850	114	25	114		238	18
19	Removal of nurse station-3003	2003	875	35	25	35		70	19
20	Carpet by aviary-3021	2003	2,884	106	25	106		212	20
21	Restripe parking lot-3028	2003	735	55	10	55		129	21
22	Landscape lake area-3068	2003	671	11	10	11		78	22
23	Landscape main entrance-3070	2003	2,625	44	10	44		306	23
24	Walls for art/music therapy room-3076	2003	2,170	9	20	9		118	24
25	Kitchen/Store/Room/Office	2004	7,200	330	20	330		330	25
26	Concrete Work	2004	1,095	55	20	55		55	26
27	Employee Smoking Area/1st Half	2004	2,500	8	25	8		8	27
28	Glass Window PT Recept Desk	2004	3,058	10	25	10		10	28
29	Floor For Tub Room 2,4,5	2004	4,819	16	25	16		16	29
30	Floor In Two Entry Baths	2004	872	3	25	3		3	30
31	Floor In Tub Room #1	2004	1,221	4	25	4		4	31
32	Employee Patio	2004	2,500	9	25	9		9	32
33									33
34	TOTAL (lines 4 thru 69)		$ 4,942,489	$ 165,217		$ 165,217	$ 0	$ 2,536,301	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,172,660	$ 110,917	$ 110,917	$	various	$ 658,442	71
72	Current Year Purchases	131,102	9,278	9,278		various	9,278	72
73	Fully Depreciated Assets	535,035				various	535,035	73
74								74
75	TOTALS	$ 1,838,797	$ 120,195	$ 120,195	$		$ 1,202,755	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1990 Van - 275	1990	$ 40,188	$	$	$		$ 40,188	76
77	Facility Business	2005 Ford 20 Passenger Bus	2004	54,530	720	720			720	77
78										78
79										79
80	TOTALS			$ 94,718	$ 720	$ 720	$		$ 40,908	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,042,299	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,132	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,132	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,779,964	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Retirement Center Apts/Duplexes	$ 6,478,785	$ 249,506	$ 3,853,059	86
87	Retirement Center Land	107,183			87
88	Other Autos	61,474	10,223	44,058	88
89					89
90					90
91	TOTALS	$ 6,647,441	$ 259,729	$ 3,897,117	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 10,618	92
93	New Building Project	132,379	93
94	Architectural Services	13,515	94
95		$ 156,512	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[x]
HOURS PER AIDE	111

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	44

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 3,064	$ 9,192	$	$ 12,256
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 3,064	$ 9,192	$	$ 12,256
10	SUM OF line 9, col. 1 and 2 (e)	$ 12,256			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	28

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 78,414	$		$ 78,414	1
2	Licensed Speech and Language Development Therapist		hrs			45,913			45,913	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			131,529			131,529	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				90,583		90,583	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 255,856	$ 90,583		$ 346,439	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,549,289	$	1
2	Cash-Patient Deposits	2,775		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	636,787		3
4	Supply Inventory (priced at)	18,866		4
5	Short-Term Investments	199,000		5
6	Prepaid Insurance	92,531		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100,000		8
9	Other(specify): Accrued Interest Receivable	1,312		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,600,560	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	273,478		13
14	Buildings, at Historical Cost	10,956,554		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,616,221		16
17	Accumulated Depreciation (book methods)	(7,677,090)		17
18	Deferred Charges	8,383		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deferred Comp Asset	152,232		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,329,778	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,930,338	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 158,420	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,775		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,226		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,322		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,772		32
33	Accrued Interest Payable	8,073		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease/Rental Deposits	77,000		36
37	Other Accrued Expenses	94,098		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 617,686	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,295,000		41
42	Deferred Compensation	152,232		42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	2,351,355		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,798,587	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,416,273	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,514,065	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,930,338	$	48

***(See instructions.)**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,243,742	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,243,742	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	270,323	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 270,323	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,514,065	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,687,075	1
2	Discounts and Allowances for all Levels	(945,911)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,741,164	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	41,506	5
6	Therapy	22,855	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 64,361	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,352	13
14	Non-Patient Meals	76,179	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,341	19
20	Radiology and X-Ray		20
21	Other Medical Services	95,698	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 231,570	23
	D. Non-Operating Revenue		
24	Contributions	10,597	24
25	Interest and Other Investment Income***	33,689	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,286	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplexes)	1,344,891	28
28a	Miscellaneous	31,183	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,376,074	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,457,455	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,579,464	31
32	Health Care	2,977,487	32
33	General Administration	1,559,423	33
	B. Capital Expense		
34	Ownership	705,156	34
	C. Ancillary Expense		
35	Special Cost Centers	289,886	35
36	Provider Participation Fee	75,716	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,187,132	40
41	**Income before Income Taxes (line 30 minus line 40)****	270,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 270,323	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,240	4,246	$ 106,679	$ 25.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,356	12,124	254,814	21.02	3
4	Licensed Practical Nurses	28,609	31,311	528,946	16.89	4
5	Nurse Aides & Orderlies	98,648	108,040	1,099,628	10.18	5
6	Nurse Aide Trainees	6,404	6,801	48,071	7.07	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,725	8,600	88,190	10.25	10
11	Social Service Workers	1,772	1,919	29,223	15.23	11
12	Dietician					12
13	Food Service Supervisor	3,273	3,789	54,697	14.44	13
14	Head Cook	8,974	9,516	95,703	10.06	14
15	Cook Helpers/Assistants	19,618	20,821	142,155	6.83	15
16	Dishwashers					16
17	Maintenance Workers	15,008	16,181	173,776	10.74	17
18	Housekeepers	20,429	22,429	188,087	8.39	18
19	Laundry	8,755	9,612	84,502	8.79	19
20	Administrator	2,080	2,086	74,125	35.53	20
21	Assistant Administrator	2,080	2,084	52,382	25.14	21
22	Other Administrative	6,346	6,607	109,810	16.62	22
23	Office Manager					23
24	Clerical	6,809	7,828	84,247	10.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,277	5,588	56,842	10.17	31
32	Other Health C: Miscellaneous	9,352	10,142	136,820	13.49	32
33	Other(specify) RC	11,930	12,929	138,835	10.74	33
34	TOTAL (lines 1 - 33)	278,685	302,653	$ 3,547,532 *	$ 11.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	203	$ 7,753	1-3	35
36	Medical Director	72	16,800	9-3	36
37	Medical Records Consultant	20	889	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	278	11-3	44
45	Social Service Consultant	4	278	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 27,298		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	2,690	57,670	10-3	52
53	TOTAL (lines 50 - 52)	2,690	$ 57,670		53

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jane Hamilton Rubin	Administrator		$ 74,125
Janet Heepke	Admissions		39,767
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,892

B. Administrative - Other

Description	Amount
Bad Debt Expense	$ 32,134
Amort of Loan Costs	2,025
Eden Alternative Training	10,731
Miscellaneous	2,763
TOTAL (agree to Schedule V, line 17, col. 3)	$ 47,653
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express	Accounting	$ 715
LarsonAllen	Accounting	38,618
Moore Diversified Service	Accounting	2,967
LarsonAllen	Accounting	1,630
Oates Associates	Consulting	295
Greensfelder	Legal	5,138
McCarthy & Associates	Legal	14,184
Coffey	Legal	6,611
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,159

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,882
Unemployment Compensation Insurance	26,267
FICA Taxes	272,354
Employee Health Insurance	265,182
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(K)	30,936
General Incentives	29,365
Employee Meals	5,230
Retirement Center Benefits	(30,799)
TOTAL (agree to Schedule V, line 22, col.8)	$ 761,417

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Marketing and Advertising	22,443
Dues & Subscriptions	8,969
Less: Public Relations Expense	(8,516)
Non-allowable advertising	(13,927)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 278
In-State Travel	2,355
Seminar Expense	1,307
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $8,544.63**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,240** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **75,716**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,230** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Larson, Allen, Weishair & Co, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.